STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155202	B. WING		04/29/2011
		1		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	R		OSPITAL DR	
WATERS	OF GREENCAST	LE, THE	I	ICASTLE, IN46135	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was fo	or a Recertification and	F0000	Preparation and\or execution	
	State Licensure	State Licensure Survey.		this plan of correction in gen or this corrective action in	erai,
	Survey dates: 4/25/11 - 4/29/11 Facility number: 000109			particular, does not constitut admission or agreement by facility of the facts alleged or	this
				conclusions set forth in this	
	Provider number	r: 155202		statement of deficiencies. T plan of correction and specification.	I
	AIM number: 100266290			corrective actions are prepa	red
				and\or executed in complian with state and federal laws.	ce
	Survey team:			with state and lederal laws.	
	Teresa Buske Ri	N 4/25-4/27/11; 4/29/11			
	Laura Brashear	RN 4/25-4/28/11			
	Mary Weyls RN				
	Census bed type				
	SNF/NF: 80	•			
	Total: 80				
	101.1. 80				
	Census payor ty	pe:			
	Medicare: 7				
	Medicaid: 56				
	Other: 17				
	Total: 80				
	Sample: 16				
	Supplemental sa	imple: 2			
	Supplemental Sa	шрю. 2			
		ies also reflect state			
	findings cited in accordance with 410 IAC				
	16.2.				
	Quality review of	completed 5-6-11			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3VE311

Facility ID:

000109

If continuation sheet

AND PLAN OF CORRECTION IDEN		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 04/29/2011
	PROVIDER OR SUPPLIER		1601	T ADDRESS, CITY, STATE, ZIP CODE HOSPITAL DR ENCASTLE, IN46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAG	Cathy Emswiller		IAU		DATE
F0278	The assessment n	nust accurately reflect the			
SS=D	_	must conduct or coordinate with the appropriate alth professionals.			
	A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.				
	who willfully and k and false statemer is subject to a civil than \$1,000 for ea individual who willi another individual false statement in	nd Medicaid, an individual nowingly certifies a material and in a resident assessment money penalty of not more ach assessment; or an fully and knowingly causes to certify a material and a resident assessment is soney penalty of not more ach assessment.			
	material and false		F0270	It is the intent of this facility t	05/20/2011
	the facility failed Minimum Data S including Care A were accurate for influenza immun of 16 residents re MDS assessment	ew and record review, to ensure residents' Set (MDS) assessments, assessment Area (CAA), r administration of aizations and/or falls for 3 eviewed with completed as in a sample of 16. Resident #8, and Resident	F0278	It is the intent of this facility to ensure all RN coordinated assessments accurately reflect the resident status on the MDS.1. Action Taken a. In regards to Resident #23; the MDS assessment was amento reflect the resident receiving the Influenza vaccination. It regards to Resident # 53; the MDS assessment was amendated assessment was amendated.	ect e nded ng b. In

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3VE311 Facility ID:

000109

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155202	B. WIN	G		04/29/2	U11
NAME OF F	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	OSPITAL DR		
WATERS	OF GREENCASTL	E, THE		GREEN	ICASTLE, IN46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	,		DATE
TAG	#23). Findings include 1. Review of the Resident # 23, or indicated the resi Influenza immun quarterly Minimu assessment, dated Annual MDS assindicated the Influot offered. Interview of LPN of Nursing) on 4/2 indicated the MD inaccurate. 2. Resident #53's reviewed on 4/28 An initial assess 10/25/11, indicated offered an influence During interview.	clinical record of a 4/26/11 at 2:15 p.m., ident received the dization on 10/14/10. The turn Data Set (MDS) at 11/15/10, and the dessment, dated 2/18/11, duenza immunization was a clinical record was 3/11 at 12:05 p.m. The clinical record was 3/11 at 12:05 p.m. The clinical record was 3/11 at 12:05 p.m. The clinical record was 3/11 at 12:05 p.m.		TAG	to reflect the resident receiving the Influenza vaccination. c. regards to Resident #8; the assessment inaccurately identified that this resident don't have falls. The Care Assessment Area was amen't to accurately reflect the resident of the resident of accurately of accurately reflect the resident of the resident of the resident of accurately reflect the resident of the resident	a. MDS id aded ent. MDS in g to ne etion ing g plan ance	DATE
	•	naccurate, in that the					

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155202	B. WING			04/29/2	011
			F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1601 H	OSPITAL DR		
WATERS	OF GREENCASTL	E, THE		GREEN	ICASTLE, IN46135		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
IAG		an influenza vaccine on	+	IAG	DEFICIENCE TY		DATE
	10/25/10.	an influenza vaccine on					
	3. Resident #8's clinical record						
	was reviewed on 4/25/11 at						
	2:30 p.m. A Minimum Data						
	Set [MDS] a	ssessment,					
	completed of	n 1/27/11 coded					
	the resident without falls. The						
	Care Assessment Area [CAA]						
	indicated mo	ost of the residents					
	falls were du	ie to the resident					
	tripping whi	le walking or					
	attempting to	o walk without					
	•	All falls are due to					
	decreased sa	fety awareness.					
	 On 4/26/11 a	at 10:30 a.m., the					
		· ·					
		inator and DON					
	indicated the	e assessment was					
	inaccurate as	s it did not pertain					
	to Resident #	¥8.					
	3.1-31(d)						

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Event ID:

3VE311

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If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 04/29/2	ETED	
	PROVIDER OR SUPPLIER		·!	1601 H	DDRESS, CITY, STATE, ZIP CODE OSPITAL DR ICASTLE, IN46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0323 SS=D	The facility must e environment rema hazards as is poss receives adequate devices to prevent Based on observarecord review, the mechanical lifts with manufactue of 2 residents observation of 2. (Resident #Findings include 1. During observation p.m., CNA's #7 are #48 from a whee Invacare Reliant During the transfelegs of the lift slit the legs of the lift slit the legs of the lift.	nsure that the resident ins as free of accident sible; and each resident accidents. Ation, interview and the facility failed to ensure were used in accordance acry recommendation for 2 served utilizing an a supplemental sample ation on 4/27/11 at 1:05 and 8 transferred resident lichair to bed with a 450 mechanical lift.	FC	323	It is the intent of this facility to ensure mechanical lifts are used in accordance with manufact recommendations. 1. Action Taken a. All nursing station-serviced in using the mechanical lifts in accordance with manufacturers recommendations. b. Proficiency audits will be completed for all nursing station the use of mechanical lifts. Others Identified a. residents who required the use of mechanical lifts would affected.3. Systems in Place a. All nursing station be in-serviced in the use of mechanical lifts per manufacturers recommendate by May 20, 2011. All newly hired nursing staff or receive in-service training in the use of mechanical during orientation. c. DON\Designee will perform random proficiency audits on mechanical lifts three timper week on each shift for the next 30 days; then one weekly on each shifts for 30 days nursing staff will perform annual proficiency on the used mechanical lifts. 4.	sed urers iff if in fts. All se of e ff will ions b. will I lifts nes e time tt 30 ekly ckly n an	05/20/2011

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN46135 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING B. WING O4/29/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN46135 (X5) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATION OF COMPLETE OF	ON (X3) DATE SURVEY COMPLETED		(X2) MULTIPLE C	IDENTIFICATION NUMBER:	OF CORRECTION	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN46135 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Monitoring STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN46135 (X2) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Monitoring A. CEO\Designee		00			OF CORRECTION	ANDILAN
WATERS OF GREENCASTLE, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) Monitoring a. CEO\Designee				100202		
WATERS OF GREENCASTLE, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Monitoring a. CEO\Designee			ı	8	PROVIDER OR SUPPLIER	NAME OF I
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Monitoring a. CEO\Designee				F. THE	OF GREENCASTI	WATERS
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Monitoring a. CEO\Designee		1				
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Monitoring a. CEO\Designee						
Monitoring a. CEO\Designee	EFERENCED TO THE APPROPRIATE	CROSS-REFEREN			`	
completed in the daily QA stand-up meeting; and will review with Medical Director in quarterly QA meeting. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5-20-11. 2. On 4/27/11 at 4 p.m., Resident # 15 was observed to be transferred from the wheelchair to the bed and then back to the wheelchair utilizing the Invacare Reliant 450 mechanical lift by CNAs #4 and #5. The resident was lifted from the wheelchair with the base of the lift in the widest open position. The base of the lift was closed by the CNA when the resident was moved away from the wheelchair. The base remained closed as the resident was lowered onto the bed and when the resident was lifted again from the bed after incontinence care. The CNAs kept the base of the lift closed until it was opened around the wheelchair. Review of the Manufacturer's Guidelines for the Invacare Reliant 450 on 4/29/11 at 10:55 a.m. indicated "ONLY operate this left with the legs in MAXIMUM OPEN POSITION and LOCKED in place. The base legs MUST be locked in the open position at all times for stability and patient safety when lifting and transferring	pring a. CEO\Designee view all proficiency's as eted in the daily QA up meeting; and will review ledical Director in rrly QA meeting. 5. This f correction constitutes our le allegation of compliance I regulatory requirements. ate of compliance is	Monitoring will review a completed ir stand-up me with Medica quarterly QA plan of corre credible alle with all regu Our date of	TAG	4 p.m., Resident # 15 be transferred from the e bed and then back to the ing the Invacare Reliant lift by CNAs #4 and #5. If lifted from the the base of the lift in the tion. The base of the lift e CNA when the resident of the bed and when the ed again from the bed the care. The CNAs kept fft closed until it was the wheelchair. If anufacturer's Guidelines Reliant 450 on 4/29/11 at the ated "ONLY operate legs in MAXIMUM N and LOCKED in place. UST be locked in the all times for stability and	2. On 4/27/11 at was observed to wheelchair to the wheelchair utiliz 450 mechanical I The resident was wheelchair with widest open posi was closed by the was moved away. The base remained was lowered onto resident was lifter after incontinence the base of the lift opened around the Review of the M for the Invacare I 10:55 a.m. indicate this left with the OPEN POSITIO. The base legs M open position at a subserved to the subserve	TAG

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155202			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMP 04/29 /2	LETED
	PROVIDER OR SUPPLIER		STREET 1601 H	ADDRESS, CITY, STATE, ZIP CODE IOSPITAL DR NCASTLE, IN46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG	a patient" 3.1-45(a)(2)	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY		DATE

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIG	00	COMPL	ETED
		155202	A. BUII			04/29/2	011 l
			B. WIN		DDDEGG CUTY CTATE TIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
\A/ATEDO	OF OPERNOACTI	E TUE		l	OSPITAL DR		
WATERS	OF GREENCASTL	E, THE		GREEN	ICASTLE, IN46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DEFICIENCY)	
F0334	The facility must d	evelop policies and	Ī				
SS=C	procedures that er	nsure that					
	(i) Before offering the influenza immunization,						
	each resident, or t						
	•	eives education regarding					
		otential side effects of the					
	immunization;	# i #					
	(ii) Each resident is offered an influenza immunization October 1 through March 31						
		ne immunization is medically					
		the resident has already					
		furing this time period;					
		r the resident's legal					
	· ,	s the opportunity to refuse					
	immunization; and						
	(iv) The resident's	medical record includes					
	documentation that	at indicates, at a minimum,					
	the following:						
		dent or resident's legal					
	-	s provided education					
		efits and potential side					
		a immunization; and					
	` '	dent either received the ation or did not receive the					
		ation due to medical					
	contraindications						
	ooni amaloadono e	or retucal.					
	The facility must d	evelop policies and					
	procedures that er						
	(i) Before offering	the pneumococcal					
	immunization, eac	h resident, or the resident's					
		e receives education					
		efits and potential side					
	effects of the imm						
		s offered a pneumococcal					
		ess the immunization is					
	-	dicated or the resident has					
	already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse						
	immunization; and						
		medical record includes					
	(17) 1110 1001001113						

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR	AND PLAN	N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY COMPLETED 04/29/2011	
WATERS OF GREENCASTLE, THE GREENCASTLE, IN46135			 	STREET A 1601 H	OSPITAL DR		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization or the resident's legal representative refuses the second immunization.	(X4) ID PREFIX	SUMMARY S (EACH DEFICIENT REGULATORY OR documentation that the following: (A) That the resist representative was regarding the ben effects of pneumococcal impreceive the pneumococcal in the resident and/representative work the influenza immunizations identified receive pneumococcal in of 16. (Resident #45, Resident #45, Resident #45, Resident #11, R	statement of deficiencies acty must be perceded by full act indicated, at a minimum, dent or resident's legal is provided education efits and potential side acoccal immunization; and dent either received the munization or did not accoccal immunization due andication or refusal. ve, based on an accitioner a second pneumococcal be given after 5 years pneumococcal ess medically the resident or the presentative refuses the tion. review and interview, define to ensure each residents' ancluded documentation of for residents' legal ere provided the benefits and/or pneumococcal for 13 of 16 residents and/or pneumococcal for 13 of 16 residents and/or mmunization in a sample at #79, Resident #39, acsident #8, Resident #53, acsident #23, Resident #24, acsident #40, Resident active Resident #26). This had affect 80 of 80 residents.	ID PREFIX TAG	It is the intent of this facility each residents medical recoinclude documentation of the resident and/or residents le representative that they have been provided the information regards to the benefits of the influenza or/or pneumococcimmunizations. 1. Action Taken a. The facility at the current CDC informations sheet listing the Benef Potential side effects to the consent form for the Influenza/Pneumococcal vaccinations. A copy of this information will be provided the representative, and a could be maintained on the resident's clinical records.	that ord ne gal ve ion in ne cal dded n its and sites and se vided legal copy rd. 2.	ETION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 04/29/2	ETED
NAME OF PROVIDER OR SUPPLIE		•	1601 H	DDDRESS, CITY, STATE, ZIP CODE OSPITAL DR ICASTLE, IN46135	'	
WATERS OF GREENCAST (X4) ID SUMMARY PREFIX (EACH DEFICIENT REGULATORY OF The Tag of the Resident #23 on indicated the resinfluenza immunity and proposed to the Tag of the Resident #22 on indicated the resinfluenza immunity and proposed to the Resident #22 on indicated the resinfluenza immunity and immu	LE, THE STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL RESCIDENTIFYING INFORMATION) Reclinical record of 14/26/11 at 2:15 p.m. Rident received the Inization on 10/14/10. In the benefits for the Induced are cord of 14/29/11 at 12:05 p.m. Rident received the Inization in October of Itation of the benefits for the Itation on 10/18/10. Itation of the benefits for the Itation on 10/18/10. Itation of the benefits for the Itation on 10/18/10. Itation of the benefits for the Itation on 10/18/10. Itation of the benefits for the Itation on 10/18/10. Itation of the benefits for the Itation on 10/18/10. Itation of the benefits for the Itation on 10/18/10. Itation of the benefits for the Itation on 10/18/10.	B. WIN	1601 H	OSPITAL DR	side all ll also ring on nee npleted edical redible th all our	(X5) COMPLETION DATE
4. Review of the Resident #24 on indicated the resinfluenza immunity Documentation influenza immunity.	e clinical record of 4/27/11 at 12:45 p.m. sident received the nization on 10/18/10. of the benefits for the nization being maintained ecord was lacking.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155202 04/29/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1601 HOSPITAL DR WATERS OF GREENCASTLE. THE GREENCASTLE, IN46135 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE It is the intent of this facility that 5. Resident #45's clinical record was F0334 05/20/2011 each residents medical record reviewed on 4/26/11 at 2:25 p.m. include documentation of the resident and\or residents legal Documentation indicated the resident representative that they have received a influenza vaccine on 10/21/10. been provided the information in regards to the benefits of the influenza or\or pneumococcal Information regarding the benefits of immunizations. 1. Action influenza and pneumovac immunizations Taken a. The facility added the current CDC information were lacking. sheet listing the Benefits and Potential side effects to the 6. Resident #40's clinical record was consent form for the reviewed on 4/27/11 at 4:30 p.m. Influenza\Pneumococcal vaccinations. A copy of this information will be provided Documentation indicated the resident to the resident and\or their legal received a influenza vaccine on 10/18/10. representative, and a copy will be maintained on the resident's clinical record. 2. Information regarding the benefits of Others Identified a. Current influenza and pneumococcal vaccine period ended March immunizations were lacking. b. No findings3. Systems In Place 7. Resident #79's clinical record was 2011\2012 Influenza\Pneumococcal reviewed on 4/25/11 at 2:25 p.m. consents will include the benefits and possible side Information regarding the benefits of effects of immunization to all influenza and pneumovac immunizations resident\legal representatives; a copy will also were lacking. by maintained on the residents' clinical record. 4. During interview of LPN #10 on 4/29/11 Monitoring a. at 10:55 a.m., the LPN provided DON\Designee will audit all resident clinical records during documentation indicating the resident 2011\2012 immunization received an influenza vaccine on 3/22/11. period. b. CEO\Designee will review all audits as completed 8. Resident #39's clinical record was and will review with Medical Director in the quarterly QA reviewed on 4/26/11 at 11 a.m.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155202		LDING	NSTRUCTION 00	(X3) DATE COMPI 04/29/2	LETED	
	PROVIDER OR SUPPLIER		 1601 H	ADDRESS, CITY, STATE, ZIP CODE OSPITAL DR ICASTLE, IN46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	Documentation is received a influenza and prower lacking. 9. Resident #53's reviewed on 4/27 Information regainfluenza and prower lacking. During interviewed at 10:55 a.m., the resident received 10/25/10. 10. Resident record was record was resident received the resident received to representation or representation or representation.	ndicated the resident nza vaccine on 10/13/10 rding the benefits of eumovac immunizations sclinical record was 1/11 at 12:05 p.m. rding the benefits of eumovac immunization rding the benefits of eumovac immunization record was 1/12:05 p.m. rding the benefits of eumovac immunization record the a influenza vaccine on 1/2 which is clinical eviewed on 1/30 p.m. It is not was noted of receiving the flu		CROSS-REFERENCED TO THE APPROPE	redible th all	
	as document					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL		
11112 12111	or confidence.	155202	A. BUII B. WIN			04/29/2	
NAME OF F	PROVIDER OR SUPPLIER		J. (12)	_	ADDRESS, CITY, STATE, ZIP CODE		
	OF GREENCASTL			1	OSPITAL DR ICASTLE, IN46135		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	10A01EE, 11440100		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ng maintained on					
	the medical	record was lacking.					
	11. Resident	#59 's clinical					
	record was r	eviewed on					
	4/27/11 at 10						
	Documentat	ion was noted of					
	the resident	receiving the flu					
	vaccine on 10/18/10.						
	Documentat	ion of the resident					
	or representa	ative being made					
	•	benefits of the					
		munization as well					
	as document						
		ng maintained on					
		record was lacking.					
	are medical	ittora mas marring.					
	12. Resident	#11's clinical					
	record was r						
	4/27/11 at 2:						
		ion was noted of					
		receiving the flu					
	vaccine on 1	•					
		ion of the resident					
	oi representa	ative being made					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED			
		155202	A. BUII B. WIN			04/29/2011			
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
WATERS OF GREENCASTLE, THE				1601 HOSPITAL DR GREENCASTLE, IN46135					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRE		TION (X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG			COMPLETION DATE		
	aware of the benefits of the						J.II.Z		
	influenza immunization as well								
	as documentation of the								
	benefits being maintained on								
	the medical record was lacking.								
	13. Resident #1's clinical								
	record was reviewed on								
	4/28/11 at 2:30 p.m. An								
	admission date was noted of								
	3/6/09 and readmission date of								
	8/12/09. Documentation of the resident or representative being made aware of the benefits of the influenza immunization as well as documentation of the benefits being maintained on								
	the medical	record was lacking.							
		-							
	Interview of	LPN #6 ADON on							
	4/29/11 at 11	a.m. indicated the							
	benefits of the	ne influenza and/or							
	pneumococc	al immunizations							
	-	o the resident							
	_	y representative.							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155202		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 04/29/2011			
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN46135					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	However, documentation of the benefits were not maintained on the residents' clinical							
	records.							
	Review of the current facility							
	policy and procedure titled							
	"INFLUENZ	ZA AND						
	PNEUMOC	OCCAL						
	VACCINAT	ION" dated 9/08						
	on 4/29/11 at 11:45 a.m.							
		.5. Inform each						
	resident/responsible party of							
		and potential side						
		e Influenza or						
	Pneumococo	cal vaccine"						
	2 1 12(-)							
	3.1-13(a)							